WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

Issued in accordance with section 294 of the *Workplace Injury Management and Workers Compensation Act 1998*

Matter Number: **6185/19**
Applicant: **VICKY CHRISTIAN**
Date of Determination: **28 February 2020**
Citation: **[2020] NSWWCC 56**

The Commission determines:

1. The respondent is to pay the applicant's section 60 of the *Workers Compensation Act 1987* expenses on production of accounts/receipts.

2. The claim for section 66 of the *Workers Compensation Act 1987* lump sum compensation is remitted to the Registrar for referral to an Approved Medical Specialist for injury on 30 January 2015 to assess whole person impairment as follows:

    (a) Cervical spine;
    (b) Right upper extremity (elbow; shoulder);
    (c) Scarring (TEMSKI).

3. The documents annexed to the Application to Resolve a Dispute and the Reply are before the AMS; there are no additional documents.

A brief statement is attached setting out the Commission's reasons for the determination.

Ross Bell
Arbitrator

I CERTIFY THAT THIS PAGE AND THE FOLLOWING PAGES IS A TRUE AND ACCURATE RECORD OF THE CERTIFICATE OF DETERMINATION AND REASONS FOR DECISION OF ROSS BELL, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A MacLeod

Ann MacLeod
Acting Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. This Application to Resolve a Dispute (Application) is in respect of a claim for injuries to the right arm and neck in a fall on 30 January 2015. The insurer denied the claim in a notice dated 22 March 2019. The Application is for section 60 of the *Workers Compensation Act 1987* (1987 Act) medical expenses; and section 66 of the 1987 Act lump sum compensation.

ISSUES FOR DETERMINATION

2. The following issues remain in dispute:

    (a) Did Ms Christian suffer an injury to her cervical spine in the fall on 30 January 2015, either as a personal injury under s 4(a) of the 1987 Act, or as the aggravation, acceleration, exacerbation or deterioration of a disease (s 4(b)(ii)?

    (b) If so, was the employment the main contributing factor to the aggravation, acceleration, exacerbation or deterioration to injury under s 4(b)(ii)?

    (c) Did Ms Christian suffer a consequential injury in the form of the aggravation, acceleration, exacerbation or deterioration of a disease as a result of the fall on 30 January 2015?

    (d) Is Ms Christian entitled to compensation for medical expenses for the claimed injury? (s 60 of the 1987 Act); and

    (e) Should the claim for lump sum compensation for the cervical spine be remitted to the Registrar for referral to an Approved Medical Specialist (AMS) (s 66 of the 1987 Act)?

PROCEDURE BEFORE THE COMMISSION

3. The parties attended a conciliation conference and arbitration hearing on 31 January 2020. I am satisfied that the parties to the dispute understand the nature of the application and the legal implications of any assertion made in the information supplied. I have used my best endeavours in attempting to bring the parties to the dispute to a settlement acceptable to all of them. I am satisfied that the parties have had sufficient opportunity to explore settlement and that they have been unable to reach an agreed resolution of the dispute.

EVIDENCE

Oral evidence

4. There was no oral evidence adduced.

Documentary evidence

5. The following documents were in evidence before the Commission and I have taken them into account in making this determination:

    (a) Application to Resolve a Dispute with annexed documents.
    (b) Reply with annexed documents.

SUBMISSIONS

6. The representatives made oral submissions at the arbitration hearing. As they were recorded they will not be repeated here, but I have taken them into account, and they are referred to in the discussion below.

Did Ms Christian suffer injury to her cervical spine in the fall on 30 January 2015; and/or suffer consequential injury to the cervical spine as a result of the injury on 30 Janaury 2015?

7. Ms Christian began work with the respondent at Alexandria in September 2013 as a production manager. In December 2014 she took on the role of Quality Control Manager, involving computer and clerical duties as well as some measuring and fitting. On 30 January 2015 Ms Christian stepped outat aproximately 1:30 pm for some lunch across the road.

8. She stumbled over a slight rise in the footpath and fell, putting her arms out to break her fall, but fell heavily on her right hand. She felt severe pain at the right elbow. She was taken by ambulance to Royal Prince Alfred Hospital where, after admission, an MRI of the right elbow revealed right radial head fracture, coronoid fracture, and lateral collateral ligament (LCL) disruption. After review by Dr C Smithers, orthopaedic surgeon, in the days following, he performed right radial head replacement, coronoid fixation and LCL reconstruction. She was discharged on 5 February 2015.

9. She was given a removable brace to hold the the right elbow in position. She also commenced a physiotherapy program. On 16 March 2015 Ms Christian had an x-ray of the elbow and wrist, showing some issues in the elbow following the surgery and a possible undisplaced fracture in the wrist.

10. While undertaking the physiotherapy treatment after the surgery she developed intense pain in the right shoulder. Her general practitioner, Dr Voutos, referred her for an ultrasound which revealed sub deltoid bursitis with impingement and adhesive capsulitis. The treatment brought about improvement and she was approved for light duties on 12 May 2015. However, she was terminated from her employment on 14 May 2015.

11. She had a cortisone injuection into the shoulder and further physiotherapy. The range of motion continued to improve with physiotherapy but the pain persisted. Dr Smithers made a referral for right shoulder MRI which found a full thickness tear. She underwent rotator cuff repair, acromioplasty and biceps tenodesis, and the arm was placed in a sling for some six weeks. The unremitting symptoms in the shoulder led to a further MRI in December 2016 which showed an intact rotator cuff repair.

12. Ms Christian was then successful in finding part-time work with another fashion company three days per week in a measuring and design role. Despite assurances as to the success of the surgical procedures and ongoing treatment, the pain in the right shoulder and right elbow continued.

13. Ms Christian says she also had pain in her neck area. She says she had been pre-occupied with the pain in her elbow and shoulder, and cannot recall when she began to notice neck pain. She says she was unaware as to whether some of the pain in the right shoulder emanated from her neck. Ms Christian states that some of the pain felt in the shoulder from the time of the fall could have been from the neck, but it was not diagnosed because of the right shoulder symptoms.

14. Dr Smithers as treating surgeon noted on 5 February 2016 that physiotherapy was assisting only partially for neck and shoulder pain. It was only in June 2018 that Ms Christian was investigated for neck pathology after Dr Smithers' decision for referral for cervical MRI in October 2017, which eventally took place in June 2018, revealing the cervical pathology.

15. It was submitted for Ms Christian that she injured her neck in the fall on 30 January 2015, and also that she suffered consequential injury to the neck due to the treatment for her injured right shoulder and elbow, and changes in the use of the arm as a result, including the use of a brace and sling.

16. Ms Christian relies on independent expert Dr J C Beer, orthopaedic specialist. Dr Beer's first report of 11 September 2018 contains the history of injury and subsequent treatment for the elbow and shoulder injuries. He also records the history of neck pain and the area of the lower right side involved. Dr Beer, after examination and viewing the MRI films, diagnoses soft tissue injury and aggravation of degenerative changes in the C4/5, C5/6 and C6/7 regions "which persist now following the injury."

17. Dr Beer in his report of 7 November 2018 had the benefit of the MRI of June 2018 and gives his opinion as to the injury to the cervical spine being in the nature of the aggravation of the pre-exisitng asymptomatic degenerative changes seen in the imaging. Dr Beer also notes that apparently "no consultation or treatment from local medical or specialist medical officers had occurred."

18. Dr Beer's reports of 29 October 2019 record the symptoms from the neck and he confirms the history with Ms Christian, recording that from the time of the fall there was pain in the same part of the neck at the C5/6/7 levels and at the muscles of the shoulder/neck angle junction. He records the history that Ms Christian had neck pain as welll as the shoulder, saying, "It was all as one part, the shoulder and the neck together."

19. Dr Beer reiterates his view that the neck injury was "directly related to the fall", but adds that, "As well, the neck and right shoulder symptoms increased also as a consequence of the injury."

20. Asked about the possibility of the elbow and shoulder injuries masking pain from the neck, Dr Beer says,

> "When speaking and discussing the issue with the worker this morning, she always had pain in the cervical spine region she contributed as "all in one" with the shoulder pain, but the pain in the cervical spine was always present she related and became more obvious when the shoulder pain settled to a certain degree with treatment but the pain in the right side of her neck persisted. Also, I feel, myself, that it was added as a consequent condition, restricted movement, with capsulitis of the right shoulder. She relates with the sore neck, when she had the surgery and she could not move her arm for 6 weeks or so, then she had the episode of the frozen shoulder, - all placed strain on the side of her neck and she felt the symptoms in her neck.
>
> When she was having physiotherapy treatment, the treatment she was getting was not only to the top of her shoulder but the treatment extended to the side of her neck and back of her shoulder, she relates. 'The treatment was all over, not just on the edge of the shoulder but to lower third of the neck on the right side as well as the top of the right shoulder."

21. This history about the physiotherapy is consistent with Dr Smithers' report of February 2016. Dr Beer explains the consequential injury process at the neck as, "The fractures of the elbow and shoulder with stiffness and immobilisation placing extra stress on the muscle function and the root of the neck structures."

22. When asked about Dr Quain's report, Dr Beer said he agrees with many of his findings but felt Dr Quain did not comment on the severity of the disc changes of C5/6 and C6/7 as seen in the MRI films which are the "sites of the consistent and persistent tenderness and complaints by the worker. Also, the consistent and persistent localised limitation of full right rotation and lateral flexion of the cervical spine."

23. In the assessment report of 29 October 2019 Dr Beer further discusses what he sees as the correlation between "marked changes" at C5/6 and C6/7 and the consistent problems in the neck from the time of injury. He also sees further aggravation consequential to "a painful stiff elbow and shoulder and cervico-dorsal musculature". Dr Beer assesses 7% WPI for the cervical spine with a deduction of 1/10 for the pre-existing asymptomatic degenerative element, giving 6% WPI.

24. The respondent submits that there is no contemporaneous evidence of injury to the neck in the fall, with the first report of symptoms after two bouts of surgery. It is submitted that the general practitioner Dr Voutos did not mention the neck in his report of 4 September 2017. In the report of 8 October 2019 Dr Voutos is of the opinion that "The neck pain was caused by the restricted right arm movement and over compensation."

25. In *Federal Broom Co Pty Ltd v Semlitch* [1964] HCA 34 (*Semlitch*) Windeyer J said in establishing whether there has been an aggravation, acceleration, exacerbation or deterioration of a disease, "… the answer depends upon whether for the sufferer the consequences of his affliction have become more serious" (at 637). This approach has been followed more recently in *Kelly v Western Institute NSW TAFE Commission* [2010] NSWWCCPD 71 (*Kelly*) in which Roche DP cited *Semlitch*, observing,

> "An aggravation or exacerbation of a disease occurs where the experience of the disease by the applicant is increased or intensified by an increase or intensifying of symptoms." (at [66])

26. The respondent submits that the neck issues only arose when Ms Christian saw Dr Beer. I do not accept that submission because Dr Smithers records the neck pain in his report of 5 February 2016 noting that physiotherapy was only partially helping the shoulder and neck pain. This places awareness of neck pain earlier than February 2016. Dr Smithers refers again to the neck problems in his report of 13 October 2017, and records that Ms Christian was to be referred for cervical spine MRI, which was not actually undertaken until June 2018.

27. Dr Beer addresses the history of symptoms following the fall in considerable depth, and worked to separate the serious and very adjacent shoulder symptoms from those in the neck. Dr Beer was obliged to consider the effect of the fall in circumstances where there had also been increased neck symptoms after immobilisation due to the use of a brace and sling and the advent of adhesives capsulitis at the shoulder. Ms Christian in her statement is unable to say exactly when the neck symptoms came on. They are not mentioned in the reports until Dr Smithers' report of 5 February 2016. The effect of the surgeries, immobilisation and general changes in right arm usage on the cervical spine had been an element for a considerable time by then.

28. The general practitioner Dr Voutos sees the neck problems as being consequential to the injuries in the fall. Dr Quain is of the view that the neck was not injured in the fall, but his reasons for this opinion are not expanded.

29. Dr Smithers on 30 July 2018 noted of the MRI in June,

> "There was some minor 3/4 foraminal narrowing on the contralateral left side only. She continues to have pain in the paracervical, trapezial and posterior deltoid regions which is exacerbated with palpation of these muscles. She understands that this is not consistent with pain related to her rotator cuff."

30. Dr Beer is of the view that the degenerative issues at C5/6 and C6/7 are significant as being the potential source of Ms Christian's symptoms in the lower neck area on the right side. He is the only practitioner who has carefully delved into the history with Ms Christian to allow the identifiaction of two elements of aggravation. Ms Christian herself in her statement is unsure as to when she first noticed the neck symptoms. Taking this together with the history elicited by Dr Beer it seems to me Ms Christian was not aware of neck issues until some point before 5 February 2016 when they were referred to by Dr Smithers in the context of physiotherapy treament beforehand. She could not be expected to be able to identifiy multiple sources of her pain in the context of the serious right shoulder condition. This distinction was achieved with the assistance of Dr Beer eliciting a more detailed history with expert questioning including identifying the site of the symptoms.

31. That there was no need seen by the treating doctors for investigation of the cervical spine until October 2017, after the two bouts of surgery, is not conclusive of there being no neck pain immediately after the fall. The exploration by Dr Beer with Ms Christian identified the area of symptoms which is the same today, and according to Ms Christian has been at the same area throughout.

32. In the circumstances of this matter, the elbow and the shoulder were the focus over a long period up to 2017, both being subject to serious injury. It is not surprising that the neck issue was lost among the concerns first about the elbow and then the shoulder. The Commission sees many such instances of multiple injuries in which the less serious are be overlooked for a period while the more serous problems are treated.

33. Dr Beer records a history from Ms Christian that the pain in the lower neck and shoulder was "all in one". Dr Beer gives a detailed report of his examination of Ms Christian and the history taken with the clear intention of working back to the time of the fall. Dr Beer puts this all together and finds that the lower cervical pathology at C5/6 and C6/7 seen on the MRI of June 2018 is consistent with the symptoms since the fall. The correlation he finds between the MRI and the lower level pathology seen is compelling. I am satisfied there was injury in the fall itself in the form of the aggravation of pre-existing degenerative disease.

34. Dr Beer was able to delve further with Ms Christian's assistance at examination than she herself has been able to do in her statement. It seems to me that Ms Christian was, over the first eighteen months or so, unable to distinguish between shoulder and cervical symptoms due to their close proximity. Dr Beer explored the nature and location of the neck symptoms and came to the conclusion that there was an aggravation in the fall of the underlying degenerative changes seen in the MRI of June 2018, particularly at the lower cervical levels.

35. Dr Beer also concluded that there was a consequential aggravation of the neck due to the immobilisation of the arm and the emergence of adhesive capsulitis. I accept Dr Beer's opinion. Dr Quain for the respondent does not consider the history in the depth of Dr Beer, and I prefer Dr Beer's opinion over that of Dr Quain for that reason.

36. In the familiar case of *Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452 the Court said,

> "The result of the cases is that each case where causation is in issue in a workers compensation claim, must be determined on its own facts. … What is required is a commonsense evaluation of the causal chain."

37. It has been indicated by the High Court since that the "commonsense" concept does not operate at large. All the evidence must be considered, with the onus of proof on the applicant throughout.[1]

[1] *March v Stramare (E & M H) Pty Limited* [1991] HCA 12; (1991) 171 CLR 506; *Flounders v Millar* [2007] NSWCA 238

38. The evidence of symptoms later causing Dr Smithers to arrange the MRI by October 2017 fits with a consequential effect on the cervical spine caused by the restricted movement of the right arm after the surgeries, and due to adhesive capsulitis. As the shoulder settled down somewhat and the symptoms in the lower neck increased, the neck became a subject of medical concern.

39. I accept Dr Beer's opinion that there was also a consequential injury to the cervical spine in the form of the aggravation of degenerative change, particularly at C5/6 and C6/7 caused by the immobilisation of the right arm arising from the serious elbow and shoulder injuries and the adhesive capsulitis that developed in the right shoulder. Dr Beer's opinion satisfies the test from *Semlitch* and *Kelly* for an increase in symptoms and the referral for a cervical MRI by Dr Smithers in October 2017 is consistent with it.

40. Dr Beers opinion satisfies the test in *Hancock v East Coast Timber Products Pty Ltd* [2011] NSWCA 11. He sets out the facts observed, the assumed facts including the history provided by Ms Christian, and takes account of the imaging.

41. Dr Quain for the respondent does not address the issue of consequential aggravation of the cervical condition due to the immobilisation of the right arm, and is therefore of no assistance on that allegation.

42. Section 4(b)(ii) requires that for injury to be proven the employment must be the main contributing factor to the aggravation. This is a more stringent test than that for s 9A of the 1987 Act requiring the employment to be "a substantial contributing factor", and which applied with disease injuries before the 2012 amendments. There can only be one "main contributing factor" for each injury.

43. The question of main contributing factor is relevant to the aggravation to the cervical spine in the fall, but is not a consideration for the consequential injury, just as section 9A was not relevant for consequential injuries before the 2012 amendments. Even if it were relevant there is only the one contributing factor of the employment in the aggravation in both injuries.

44. The respondent submits that Dr Beer gives no opinion on main contributing factor, but this is not fatal to the claim. In *State Transit Authority of New South Wales v El-Achi* [2015] NSWWCCPD 71 Roche DP said [at 72],

> "That a doctor does not address the ultimate legal question to be decided is not fatal (*Guthrie v Spence* [2009] NSWCA 369; 78 NSWLR 225 at [194] to [199] and [203]). In the Commission, an Arbitrator must determine, having regard to *the whole of the evidence*, the issue of injury, and whether employment is the main contributing factor to the injury. That involves an evaluative process."

45. Roche DP also referred to the test for main contributing factor as being one of causation. This requires consideration of the competing causal factors. The factor must be the main contributing factor to the aggravation, not to the underlying pre-existing condition.

46. There are no competing factors to the aggravation of the cervical spine in the fall. There is no other factor on the evidence overall, and the test of main contributing factor is satisfied for the claimed injury.

47. For these reasons I find that the employment was the main contributing factor to the aggravation, acceleration, exacerbation or deterioration of the underlying degenerative changes in Ms Christian's cervical spine in the fall on 30 January 2015.

48. On all the evidence, including Dr Beer's opinion, there is a clear chain of causation from the injury in January 2015 through the surgeries to the right elbow and shoulder, the immobilisation of the right arm, the adhesive capsulitis in the shoulder, resulting in the aggravation of the degenerative changes in the cervical spine.

Conclusion

49. I find that Ms Christian suffered in the course of her employment with the respondent:

    (a) injury of the aggravation, acceleration, exacerbation or deterioration of a disease process in her cervical spine in the fall on 30 January 2015; and
    (b) consequential injury to the cervical spine in the form of the aggravation, acceleration, exacerbation or deterioration of a disease process as a result of the injury to the right elbow and shoulder on 30 January 2015.

Section 60 of the 1987 Act medical expenses

50. It follows from the above findings that Ms Christian is entitled for s 60 medical expenses for the injuries.

Section 66 of the 1987 Act lump sum compensation

51. It also follows that the claim for lump sum compensation for the cervical spine is to be remitted to the Registrar for referral to an AMS together with the other body parts claimed.

SUMMARY

52. Ms Christian suffered:

    (a) injury of the aggravation, acceleration, exacerbation or deterioration of a disease process in her cervical spine in the fall on 30 January 2015 (s 4(b)(ii) of the 1987 Act); and
    (b) consequential injury to the cervical spine in the form of the aggravation, acceleration, exacerbation or deterioration of a disease process as a result of the injury to the right upper extremity on 30 January 2015.

53. There is to be an order for s 60 of the 1987 Act expenses for the compensable injury.

54. The claims for s 66 of the 1987 Act lump sum compensation are to be remitted to the Registrar for referral to an AMS.